Trauma Reenactment: Rethinking Borderline Personality Disorder When Diagnosing Sexual Abuse Survivors

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Adult survivors of sexual trauma often experience symptoms related to their childhood experiences that are analogous to many of the diagnostic criteria of Borderline Personality Disorder (BPD). This article examines these symptoms in the context of a trauma framework and postulates that mental health counselors need to consider if the symptomatic behaviors are more indicative of a post-traumatic response, specifically trauma reenactment. Recognizing self-harming behaviors in adult survivors as reenactments of childhood sexual trauma rather than characterological manifestations of personality deficits serves to improve the quality of care of such clients in that mental health counselors may then focus on the unresolved issues rather than personality restructuring. Thus, understanding clients from a trauma framework can minimize the stigma that is often associated with the diagnosis of BPD and provide a more objective treatment climate.

Borderline Personality Disorder (BPD) has been a topic of interest for mental health professionals for some time. Literature abounds discussing the etiology and effective treatment methodology for individuals with this diagnosis. In recent years, the professional literature has attended to the similarities between BPD and Post Traumatic Stress Disorder (PTSD) (Hodges, 2003; Murray, 1993). Miller (1994) suggested that BPD might, in fact, be misdiagnosed in cases of sexual abuse survivors. Rather than a...
diagnosis of BPD, the symptomology of the client may be more reflective of a Post Traumatic Stress Disorder (PTSD) diagnosis, and, more specifically, in line with trauma reenactment. Although not a diagnostic category recognized by the American Psychiatric Association (APA, 2000), for the purpose of this article, trauma reenactment will be considered a form of PTSD.

Freud (1920) suggested that individuals who survived traumatic events may develop what he termed traumatic neurosis. One consequence of traumatic neurosis is the survivors' compulsion to repeat elements of the traumatic event. Similar to Freud's concept, Miller (1994) postulated that adult survivors of childhood sexual trauma who engage in self-injurious behavior, engage in risk-taking behaviors such as promiscuity and substance abuse, and experience difficulties in interpersonal relationships, are actually reenacting behaviors symbolic of trauma suffered in childhood. Types of reenactment these individuals engage in may include (a) behavioral (i.e., inflicting harm to self or others), (b) self-destructiveness (i.e., subconsciously sabotaging situations such that it leads to feelings of revictimization), and (c) reexperiencing (flashbacks).

Several theories exist which attempt to explain the etiology of these reenactment behaviors. One such theory was proposed by van der Kolk (1989). He posited that these individuals are addicted to the trauma and, therefore, may try to recreate it (i.e. a victim of childhood sexual abuse may become a prostitute). Such individuals have reported feeling bored, apprehensive, and anxious when not experiencing some form of activity reminiscent of their trauma. Miller (1994) suggested that this arousal need can be an impetus for reenactment behaviors. For children who experience trauma, these experiences became synonymous with relationships and the child is often in a constant state of arousal due to fear, rage, hyperalertness, or anxiety. This constant arousal impacts the biochemistry of the child and inhibits a return to a baseline. Thus, as an adult, the individual may be addicted to excitement which is painful, while also to them, pleasurable and comfortable. Further, van der Kolk (1989) reported that high levels of stress activate the physiological opioid systems. Just as heroin may activate this system and create a cycle of dependence and withdrawal, so might the hyperarousal that is created with trauma. Self-injurious behaviors perpetuate this cycle by producing the stress related opioid stimulation. To further substantiate this theory, van der Kolk highlighted the benefits of opioid receptor blockade medications in decreasing self-mutilative behaviors.

Miller (1994) suggested that the process of trauma reenactment is cyclical and includes thoughts, feelings, and behavior that can be interpreted at any point in the cycle. At one point, the cycle could be interpreted as
feelings of rage, shame, or fear causing an individual to inflict self-harm. At another juncture, it could be interpreted that self-harming causes disgust that results in further punishment, or finally, it could be interpreted that when an interpersonal relationship becomes too intimate the individual feels compelled to detach through self-harming behaviors. The self-abuse cycle serves to protect the trauma survivor as it keeps others at a distance. The self-protective function of self-harming behaviors is necessary as survivors are often unable to self-protect and typically maintain diffuse boundaries in interpersonal relationships. Paradoxically, these individuals also want to be rescued and protected. Together these tendencies create relational instability.

In this article, we discuss the impact of childhood sexual abuse on development and attachment and how traumatic experiences in childhood may result in reenactment behaviors as adults. We then explore the association between reenactment symptoms and the DSM-IV-TR diagnostic categories of BPD and PTSD. Finally, we challenge the use of the BPD diagnosis when treating survivors of sexual trauma as such a diagnosis may not be clinically accurate and may have a stigmatizing impact that can be more harmful than beneficial.

**IMPACT OF TRAUMA ON DEVELOPMENT**

Traumatic childhood experiences may impede the normal developmental process. Janet (1911) suggested that personality development is halted by traumatic experiences. Consequently, the individual is unable to accommodate and assimilate new information from experiences, thus disturbing his or her ability to cope with future challenges. This ultimately leaves the individual unable to integrate the traumatic material into existing cognitive schemas. According to Freud (1920), individuals who are unable to assimilate traumatic experiences into the memory system repeat the repressed material as contemporary experiences and, as suggested by van der Kolk (1989), are not likely to make a conscious connection between past experiences and current reenactments.

It has been postulated that cognitive distortions result from childhood sexual trauma (Solomon & Heide, 2005). Owens and Chard (2001) suggested that these cognitive distortions impact five areas: safety, trust, power, esteem, and intimacy. The culminating effect of such distortions may result in anxiety, avoidant behavior, fear of betrayal, anger, passivity, feelings of powerlessness (Owens & Chard, 2001), and an exaggerated potential for danger (Briere & Runtz, 1993). Further, Bleiberg (1994) suggested that sexual abuse becomes part of the struggle and conflict characteristic of the developmental process and may fuel fears of
abandonment or feelings of estrangement from self and disconnection from others.

A primary issue in trauma reenactment is the absence of a protective presence in early relationships, which impairs the individual's ability to trust others, thus impacting the attachment process (Miller, 1994; 1996). According to Liotti and Pasquini (2000), intrafamilial violence such as physical and sexual abuse, as well as other traumatic conditions (e.g., witnessing violence, neglect, early separation and loss), affect the child in his or her relationship with the caregiver.

To conceptualize the implications of malformed interpersonal relationships as a consequence of early childhood traumatic experiences that ultimately result in trauma reenactment behaviors, attachment theory is explored as it relates to childhood sexual trauma. As indicated above, there is an empirically supported connection between childhood trauma, attachment, and an adult diagnosis of BPD. Because of this connection, along with similarities in the symptomology of BPD and PTSD, there is a distinct possibility that early traumas and resulting attachment difficulties may lead to an inappropriate diagnosis of BPD. Instead, these difficulties may be reflective of trauma reenactment which is far more consistent with a PTSD diagnosis.

**Attachment**

Attachment functions to provide proximity and protection: proximity between an individual and his or her caregiver and protection from predators (Bowlby, 1973). In essence, the attachment figure becomes a safe-base for children to leave, explore the world, and return. The safe-base is crucial to development as it promotes self-reliance, autonomy, empathy, and existential meaning. The absence of this safe-base can impact even biological development (van der Kolk, 1989) as evidenced by psychosocial dwarfism, the phenomenon in which children in highly stressful environments develop aberrant behaviors and growth retardation (Powell, Brasel, & Blizzard, 1967). van der Kolk (1987) suggested that the earliest and possibly most damaging psychological trauma is the loss of the safe-base. When those who are supposed to be the sources of safety and nurturance become simultaneously the sources of danger, children maneuver to re-establish some sense of safety and often blame themselves rather than turn against their caregivers (van der Kolk, 1989). Further, children strive to maintain perceptions of their parents as good in order to deal with the intense negative emotions, such as fear and rage, which often accompany sexual abuse, including fear and rage.

It is a natural process for individuals to increase attachment in response to a threat (van der Kolk, 1989). For example, with the Stockholm
Syndrome, victims of hostage situations begin to identify and empathize with their captors (Gachnochi & Skunik, 1992). When caregivers are the source of danger and torture, children may develop strong emotional ties to them. Traumatic bonding legitimizes the inappropriate behaviors and demands of the perpetrator and, thus, may provide a sense of peace for the victim. If a caregiver is rejecting and abusive, children may become hyperaroused due to conflicting negative emotions and increased attachment) and the resulting cycle of arousal and peace can serve as a powerful reinforcer (van der Kolk, 1989). In adult survivors of sexual abuse, hyperarousal often interferes with their ability to be calm and rational and prevents the assimilation of traumatic material. The adult survivor then responds to threats as emergencies requiring action rather than thought (van der Kolk, 1989).

Childhood sexual abuse interrupts attachment experiences leaving individuals with inadequate interpersonal skills often leading to disruptive and unhealthy patterns of behavior (Liem & Boudewyn, 1999). The inconsistent parental nurturing that is characteristic of unresolved attachment sets up short-circuited reception and encoding of relational stimuli in the child. According to Koos and Gergely (2001), inconsistency in infant nurturing leads to a “dissociative style of attention and behavioral organization characteristic of disorganized infant attachment” (p. 397). This primary inconsistency of care seems a logical precursor to the inconsistent emotional attachment exhibited by individuals with BPD in adult interpersonal relationships (Holmes, 2004). Herman (1999) suggested that the primary difficulty for those diagnosed with BPD is their failure to trust people, which may stem from the lack of an integrated cognitive schema representing a reliable source of trust that did not form during childhood.

Liotti and Pasquini (2000) discussed the similarities between BPD and the subsequent effects of disorganized attachment on personality development. These authors emphasized that both BPD and disorganized attachment are characterized by an unmediated representation of self-with-other, poor impulse and emotional control, and a propensity toward dissociative experiences. The effect of this fragmented process is a lack of clear boundaries and feelings of uncertainty about the security of relationships (Miller, 1994).

With individuals who are reenacting trauma, there is evidence of inconsistent attachment that impacts future relationships. Miller (1996) described the nonprotecting bystander as the parental figure who ignored the occurrence of the sexual abuse. The absence of protection from the nonprotecting bystander significantly impacts attachment. The consequences for the survivors are the inability to self-protect and self-soothe.
With this inability comes a fragmented personality experience in which the individual is unable to perceive her or himself as a whole person, thus relating to others in fragmented parts.

**Reenactments as Adults**

Once an individual has been abused, he or she can never view the self and the world in the same manner as before the abuse as all future experiences are reconstructed through the filter of abuse (van der Kolk, 1989). This filter is connected to the cognitive processes of assimilation and accommodation identified by Piaget.

Piaget (1970) described assimilation as the integration of experiences into existing cognitive schemas and accommodation as the modification of the schemas by the experiences assimilated. Van Geert (1998) further described the assimilation process as the way in which the world is understood according to the individual's level of cognitive development at the time of the experience and accommodation as the way the individual adapts him or herself to the reality of the experience. Thus, when a child experiences sexual trauma, he or she will assimilate the experience according to his or her level of cognitive development and will then accommodate to that experience.

Because the developmental process of assimilation and accommodation have such a significant impact on cognitive schemas, adults are likely to continue behaving or thinking in accordance with these schemas. For example, victims of past trauma may respond to contemporary events as though the trauma has returned and re-experience the hyperarousal that accompanied the initial trauma. Van der Kolk (1989) suggested that the adult survivor of trauma seeks to undo the past through exemplary behaviors, love, and competency. When the individual fails to resolve the trauma, self-blame occurs along with a return to earlier, self-destructive coping mechanisms.

Doob (1992) suggested that the trauma reenactment link between seeming borderline pathology and sexual trauma history is in the accommodation process. Victims of chronic abuse accommodate the abuse initially as an adaptive strategy for survival by denying its occurrence, altering his or her affective responses related to the abuse, and altering thought processes about those who are supposed to protect but instead harm them. Ultimately, these strategies result in the victim experiencing anger that is redirected toward self and ultimately results in self-harming behaviors. Thus, self-harming behaviors are essentially reenactment behaviors of the client's traumatic history. These strategies allow the child survivor to remain connected to family members. However, as adults, these accommodations, which are manifested through dissociative symp-
toms, self destruction, irrational anxiety, interpersonal conflicts, paranoia, depression, and anxiety, are viewed as psychopathology in the mental health community rather than as coping skills.

**BORDERLINE PERSONALITY DISORDER AND CHILDHOOD ABUSE**

Research shows that disturbances with attachment and bonding in early childhood affect personality development and healthy interpersonal functioning as an adult, often resulting in the development of personality disorders such as BPD (Adams, 1999; Mahler, 1971). Marked by a pattern of relational instability, identity disturbance, impulsivity, recurrent suicidal ideation or suicide attempt(s), reactive mood swings, chronic feelings of emptiness, inappropriate and/or uncontrolled and often explosive anger, physical fighting, and severe dissociative episodes (APA, 2000), persons with BPD seem driven by a paradoxical quest for close, secure relationships that they consistently sabotage. To be sure, the primary deficit in borderline personality disorder has been described as a “failure to achieve object constancy...[a] failure to form reliable and well-integrated inner representations of trusted people” (Herman, 1999, p. 125).

Many researchers have found that a significant number of individuals diagnosed with BPD have a history of childhood sexual and physical abuse (Goldman, D’Angelo, & DeMaso, 1993; Herman, Perry, & van der Kolk, 1989; Herman & van der Kolk, 1987; Zanarini, Frankenburg, Reich, & Marino, 2000). The sexual-physical trauma that occurs as a result of childhood sexual abuse contributes to an interpersonal style of functioning that involves manipulative, dependent relationships and chronic low self-esteem. Terr (1991) suggested that children exposed to trauma experiences have altered attitudes toward interpersonal relationships, life experiences, and difficulties related to their ability to consider the effects of the present on the future. Many individuals exhibiting these characteristics end up in counseling and are ultimately diagnosed with BPD.

However, while it is possible, and often likely, that the sexual trauma survivor’s symptoms are similar to the diagnostic criteria of BPD, it is imperative that mental health counselors consider the underlying motivations represented in symptoms before offering a BPD diagnosis. These underlying motivators are often a result of the survivors’ avoidance of dealing with the trauma history and ultimately lead to the development of maladaptive coping strategies. The resulting avoidance of stimuli associated with childhood trauma, including increased arousal, and re-experiencing the trauma, are distinct behaviors that characterize victims’ responses to sexual trauma (Morgan, Rigaud, & Taylor, 1990) and, thus are more consistent with PTSD diagnostic criteria. Further, when sexual
boundaries are invaded during sexual trauma experiences, victims' psychological coping strategies help repress overwhelming emotions and thoughts related to the trauma.

Repression and dissociation allow victims to cope with experiences they are unable to integrate, and when repression and dissociation begin to fail as coping mechanisms, survivors may reexperience traumatic events (Morgan, Rigaud & Taylor, 1990). Many victims experience "avoidant response breakdowns" by re-experiencing all or some aspects of their sexual trauma (Morgan et al., p. 32). For example, individuals may experience intrusive flashbacks of sensations including, sounds, smells, or tastes that were present at the time of the abuse incident. As a consequence of re-experiencing the trauma, the individual may become confused and exhibit intense emotions that can be misdiagnosed by mental health counselors. These responses are similar to the BPD characteristics of affective instability, inappropriate anger, or stress-related paranoid ideation. When considering these characteristics it seems reasonable that the symptoms that often lead to a diagnosis of BPD in adult survivors of sexual trauma may be more consistent with trauma reenactment rather than reflecting deficits in personality.

POST TRAUMATIC STRESS DISORDER

Miller (1994) suggested that distinguishing trauma reenactment from BPD involves a thorough understanding of the client's history. Individuals who are reenacting childhood trauma often have (a) a history of childhood trauma (physical, sexual, or emotional abuse, neglect, and/or invasive care taking), (b) chronic behavior that causes interpersonal and intrapersonal difficulties, and (c) behavior that is injurious to their health and well-being. These behaviors, albeit pathological, are maladaptive coping mechanisms rather than the characterological symptomatology of a personality disorder. Although these characteristics appear similar to the diagnostic criteria of BPD, a childhood sexual trauma history is not a prerequisite for the BPD diagnosis. However, it is because of traumatic events that individuals exhibit the reenactment behaviors. With PTSD being one of a few DSM-IV diagnoses that is situationally identified, it seems reasonable that it may be the more accurate diagnosis.

Post Traumatic Stress Disorder is marked by five domains: (a) psychobiological alterations (e.g., hypervigilance, proneness to anger, exaggerated startle response, sleep disturbances), (b) traumatic memory (e.g., nightmares, acting out or reliving trauma, intrusive imagery, dissociation), (c) avoidance, numbing, and denial (e.g., estrangement and detachment, substance abuse, emotional constriction), (d) self concept, ego
states, personal identity, and self-structure (e.g., identity diffusion, vulnerability, faulty cognitions about self and world), and (e) attachment, intimacy, and interpersonal relations (e.g., alienation, self-destructive relationships, mistrust, boundary problems with others, impulsiveness) (APA, 2000; Wilson, Friedman, & Lindy, 2001). These DSM-IV criteria seem similar to those discussed previously for BPD. In fact, Hodges (2003) indicated that current thinking suggests that BPD is a "chronic form of PTSD that has been integrated into the personality framework" (p. 413). The notion that PTSD may be a chronic condition was initially suggested two decades ago by Arnsworth (1984), who indicated that childhood sexual trauma survivors experiencing PTSD may have persistent symptomology throughout adulthood. More recently, Banyard, Williams, and Siegel (2000) indicated that childhood sexual trauma can have a chain reaction of psychological distress that begins in childhood and continues through adulthood.

There is empirical support that survivors of childhood sexual trauma are more likely to experience PTSD than non-survivors. Lang, et al. (2003) found that women with sexual trauma histories had significantly more PTSD symptoms than women without such histories. Further, their findings indicated that PTSD mediates the relationship between sexual trauma history and poor health behaviors, including risky sexual behaviors and substance abuse. Thompson, et al. (2003) also found statistically significant results suggesting that women who experienced childhood sexual trauma were more likely to experience PTSD symptoms than women who did not experience such trauma. Furthermore, Banyard et al. (2000) found that childhood sexual trauma is associated with PTSD symptoms of anxious arousal, depression, avoidance, intrusions, impaired self-reference, dissociation, and sexual concerns.

The above empirical support suggesting that survivors of childhood sexual trauma experience PTSD symptoms is important, but not the key to understanding and treating trauma reenactment. To provide effective services to the survivors of childhood sexual trauma, the mental health community must consider the underlying reasons why some survivors experience reenactment behaviors while others do not, though little is known about this. Banyard et al. (2000) suggested that for some, the symptoms associated with PTSD become part of their personality structure. If considering childhood sexual trauma from a learning theory framework, it makes sense that the coping and response patterns that were used during the period that the sexual trauma occurred would be the same coping and response patterns used in other life situations and, thus likely to increase the risk for future psychological issues (Banyard et al., 2000).
RETHINKING BORDERLINE PERSONALITY DISORDER

While mental health counselors may disagree on the theory and origin of BPD, few would argue against the statement that BPD is one of the most difficult forms of mental illness to treat. Individuals with BPD often present as very manipulative and mental health counselors report frustration with the cycle of manipulation and rejection by these clients. Perry (1997) suggested that mental health professionals often view individuals with the BPD diagnosis as foisting the responsibility for getting better onto the therapist, while at the same time rejecting the therapist's efforts to help. Additionally, there is a stigma associated with this diagnosis among mental health professionals which often makes BPD seem like a “death sentence” for a client (Gallop, Lancee, & Garfinkel, 1989; Nehls, 1998; Reiser & Levinson, 1984). In fact, “psychological cancer” was the term Kernberg (1984, p. 262) used to describe the BPD diagnosis. In a 1988 study by Lewis and Appleby, it was found that psychiatrists were pejorative, judgmental, and rejecting of the BPD patient and used terms such as manipulative and attention seeking to describe them. They also implied that they were not worthy of the same quality of care as other patients. Reiser and Levinson (1984) indicated that the term borderline may create a breakdown in empathy between the clinician and the client. It is indeed the case that the diagnostic criteria for BPD are similar to many of the long-term consequences of, and reactions to, childhood sexual abuse. For instance, some noted long-term consequences of sexual abuse include impaired relationships with and distrust of others, preoccupation with sexual themes and promiscuity, sexual dysfunctions, impulsivity and risk taking behaviors (e.g., substance abuse, prostitution, self-destructive behaviors), and suicidal ideation and depression (Murray, 1993). However, the stigma attached to a diagnosis of BPD may actually lead to retraumatization of the adult survivor of childhood sexual abuse during therapy. Dobb (1992) suggested that, because adult survivors often continue to “blame themselves for their victimization, explaining that they were abused because of their essential badness,” (p. 246) the label of a personality disorder may confirm this notion for the adult survivor.

Because of the similarity of symptoms in clients with BPD and clients who have been sexually abused, mental health counselors may be tempted to diagnose sexual abuse survivors with BPD. However, ethically, such a decision poses a number of dilemmas. For instance, the stigma associated with borderline personality disorder may result in discrimination by insurers or retraumatization during therapy, contradicting the pinnacle ethical guideline for counseling practice to promote the welfare and respect the dignity of clients (ACA, 1995). If the stigma that is associated
with a BPD diagnosis can impact mental health professionals in the manner described above, it is conceivable that this stigma also impacts insurance company employees. In fact, Diamond and Factor (1994) reported that those with a borderline personality diagnosis may be erroneously labeled as treatment resistant and ultimately viewed as receiving excessive services. Clients diagnosed with BPD may be red flagged by insurance companies as cost risks because of the frequent number of suicide attempts and hospitalizations associated with the diagnosis. Thus, a diagnosis of BPD may also result in insurance discrimination in terms of higher premiums or even refusals to insure.

Further, a practitioner focused on a personality disorder diagnosis, such as BPD, will likely focus on the specific features of that diagnosis and not look beyond characterological concerns to the sources of problems that keep the client repeating behavioral patterns (Miller, 1994). However, viewing the client's struggles from a trauma framework allows the counselor to view the symptoms as coping mechanisms for his or her trauma history and allows for the explanation to the client, in a nonthreatening manner of how such past experiences are being reenacted through present choices. This explanation, then, may allow the client to understand how these behaviors have served as maladaptive coping mechanisms that maintain a victim status, while providing an opportunity to learn more positive coping mechanisms. This shift in his or her thinking to a survivor status, without the blame or revictimization, is inherent in the label of personality disorder.

Although the diagnosis of BPD may be helpful for identification of behaviors when consulting with other mental health professionals, the stigma attached to the label may provide a disservice to the client by mislabeling the behaviors as characterological rather than coping behaviors (Miller, 1994). Miller further suggested that a client reenacting a childhood trauma needs to be understood through exploration of the maladaptive behaviors (e.g., self-harm, rages, relational turbulence) rather than trying to silence and contain the symptomatic behaviors. Hodges (2003) suggested that it is necessary for APA to rethink the BPD diagnosis altogether and collapse both BPD and PTSD into one Axis I diagnosis with BPD being a subclassification of PTSD. Doing so, Hodges indicated, would decrease the stigma associated with BPD and integrate two seemingly similar diagnostic categories.

Understanding a client within a PTSD framework provides the clinician with more diverse intervention options. A PTSD framework can also be integrated into the modalities that have been shown to be successful with BPD clients such as Linehan's dialectical behavior therapy (DBT) (Linehan, 1993). This approach balances the focus on change and the
patient's responsibilities to actively engage in problem solving, with a corresponding focus on empathy, validation, and active therapeutic support (Linehan, 1993; Smith & Peck, 2004). Additionally, if all treatment providers adopt this perspective, DBT coordinates care among the providers requiring on-going supervision or consultation and ultimately providing support for the mental health counselors treating the patient (Linehan, 1993; Smith & Peck, 2004). This allows the therapist an opportunity to educate the client regarding "the why" of their problematic symptoms rather than limiting therapy or following the belief systems of many mental health counselors that personality disorders can not be successfully treated (Gallop et al., 1989; Nehls, 1998).

**IMPLICATIONS FOR CLINICAL PRACTICE**

The complexity of the implications and needs of clients managing trauma reenactment symptoms create the need for comprehensive assessment, treatment planning and intervention. Therefore a therapeutic approach which integrates emotional, behavioral, and interpersonal awareness seems necessary. Additionally, creating a safe environment in which the client can openly explore their traumatic history is fundamental. Clients should be assisted in making conscious connections between their past experiences and their reenactment experiences, as recognition of this connection will allow for more adaptive coping mechanisms to enter into the clients’ conscious reactions to stressful events (Miller, 1994).

Along with the awareness of the connection between past events and current reenactment behaviors, clients should begin to recognize the maladaptive and often destructive cyclical pattern created when a client's expressed needs go unmet as a result of his or her behaviors. For clients experiencing trauma reenactment, the expressions of need (safety, trust, power, esteem and intimacy) in the way they are accustomed (reenactment behaviors), ultimately result in a rejection of any attempt by others to meet these needs, thus trapping them in a destructive cycle. Trauma reenactment clients often simultaneously elicit the closeness and emotional intimacy of a protective bystander only to ultimately reject that individual (Miller, 1994). Therefore, creating an awareness of, and acquiring the ability to, get needs met through other, more adaptive behaviors becomes key to the treatment on trauma reenactment clients.

From a cognitive perspective, the distortions that manifest from childhood trauma resulting in anxiety, avoidant behavior, fear of betrayal, anger, passivity, and feelings of powerlessness should be challenged and modified (Owens & Chard, 2001). Trauma reenactment clients may think
their "lot in life" is to constantly relive and punish themselves in reaction to the traumatic material. Additionally, they may hold onto the cognitive distortion that they are to blame and that the perpetrator is okay in an attempt to manage the cognitive dissonance that results when a caregiver is simultaneously the source of safety and danger. These and other beliefs or distortions more specific to the individual client should be challenged and ultimately modified to more empowering, self-aware cognitions.

Miller (1994) outlines four approaches to the treatment of trauma reenactment. First, she indicates that understanding the context surrounding the trauma reenactment symptoms is fundamental to understanding and treatment. Miller states that by context she is referring to "the situations in which the person lives, interacts, thinks, and experiences herself in relationship the world" (p. 38). Miller suggests that there are multiple contexts which support the pervasive logic of the reenactment. Second, the symptoms should be viewed from a historical perspective and as an adaptation and communication of the past. Third, the behavior should be seen as serving many functions even when the behavior is no longer necessary. For the trauma reenactment victims, the symptoms become a companion, far less threatening than other relationships or new experiences, and often their only source of power and control. Finally, Miller states that the trauma reenactment victim needs at least one meaningful and healthy relationship prior to revisiting the traumatic event. This is most often found in the therapeutic relationship.

In summary, as with all clients, the trauma reenactment client should be treated comprehensively and systemically. As indicated above, it would be, not only a major disservice, but ultimately not beneficial to simply treat the manifestations (the symptoms) or the behaviors which form the reenactment. More specifically, it would more than likely be ineffective to only treat the addiction, the eating disorder, and/or the self-injurious behavior.

CONCLUSION

This review of the literature supports a reevaluation of the diagnostic practices of mental health counselors when treating survivors of childhood sexual trauma. It seems that the manifestation of childhood trauma, which often results in disorganized attachment, parallels so many of the symptoms of BPD and PTSD. Although there are similarities between a borderline personality disorder diagnosis and trauma reenactment behaviors, the least restrictive environment mandate compels the counselor to consider if the client's symptoms are more reflective of PTSD, thus providing a more objective treatment climate due to the attitudes of mental health counselors toward clients baring the label of BPD. Because
of the potential for discrimination in the mental health community, it becomes exceedingly important to determine if the client's symptomology is a result of unresolved childhood trauma or a true personality disorder, which each have uniquely different treatment implications and protocols.

REFERENCES


Herman, J. (1999). Trauma and recovery: The aftermath of violence from domestic abuse to political terror. New York: Basic Books.


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